NORTH DAKOTA FAMILY CAREGIVER SUPPORT PROGRAM PROVIDER AGREEMENT

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES
SFN 128 (11-2014)

A. CONTACT INFORMATION (Indicate the type of provider)

☐ Family Member ☐ Individual Respite QSP ☐ Agency			Start Date	End Date
Individual/Agency Legal Name			Agency Contact Person	
Address (Street)			E-mail Address	
City	State	ZIP Code	Telephone Number	Cell Phone Number

B. SERVICE AND REIMBURSEMENT RATE (Indicate service(s) to be provided and hourly/daily rate)

☐ Individual/Family Counseling	$
☐ Individual Caregiver Training	$
☐ Respite Care - Daily Rate (Maximum payment for overnight/24-hour care cannot exceed the current swingbed rate.)	$
☐ Respite Care - Hourly Rate	$

C. LIST OF ELIGIBLE PROVIDERS

Indicate if you want to be included on the regional list of available service providers for the services you checked in Section B. (Provider names will remain on the list through the above stated effective date.) ☐ Yes ☐ No

D. BILLING PROCEDURES

- Submit a completed "Substitute IRS Form W-9" (SFN 54309) to the Department of Human Services Regional Human Service Center. A substitute IRS form only needs to be submitted once.
- Submit a completed North Dakota Family Caregiver Support Program (NDFCSP) Provider Service Log (SFN 135 or SFN 492) for all NDFCSP clients you serve during the billing period to the Department of Human Services Regional Human Service Center for payment. Provider Service Logs must be submitted for payment by the 5th day of the month following the month services were provided.
- **Final payment requests (SFN 135 or SFN 492) shall be submitted to the Regional Human Service Center no later than 30 days after the expiration of this agreement.**
- Payments made to you by the Department of Human Services Regional Human Services Center as a NDFCSP provider are for work performed. The payments are not a grant or other form of public aid. Therefore, the payments made to you may be subject to self-employment tax and/or you may be responsible for paying a quarterly estimated income tax. Contact your tax preparer and/or the internal revenue service regarding your need, if any, to pay self-employment tax and estimated income tax. Do not contact the Department of Human Services Regional Human Service Center with tax questions. Your tax preparer, the staff of the Social Security Administration or Internal Revenue Service have the expertise to properly advise you.

E. INITIAL EACH OF THE FOLLOWING PARAGRAPHS TO INDICATE UNDERSTANDING AND AGREEMENT

_____ The individual/agency shall notify the Family Caregiver Coordinator when possible abuse or exploitation of the client occurs.

_____ The individual/agency shall refrain from discussing any information pertaining to clients with anyone not directly associated with service delivery and shall not reveal client personal information except as necessary to comply with the law and to deliver services.

_____ The individual/agency will not accept gifts or solicit gifts or money from the client.

_____ The individual/agency shall adhere to applicable state and federal laws.

_____ (Individuals only) As a self-employed person, I am responsible for self-employment (federal social security) taxes. Further, since I am self-employed, there is no withholding of income tax; therefore, I am responsible for quarterly estimated payments to the Internal Revenue Service (IRS) as may be required.

_____ I understand that payment and satisfaction of any claim will be from federal and/or state funds, and accept, as payment in full, the amounts paid, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable federal or state laws.

_____ The parties stipulate that this agreement may be terminated at any time upon the giving of written notice to the other party.

_____ The individual/agency agrees to maintain records for each client visit that show the date of service, the amount of time spent in the client's home (units of service), and tasks performed during that time. The records must be maintained for a period of 75 months.

_____ I understand that the Department of Human Services may require an individual/agency to pay back FCSP funds that were received by the provider as the result of an overpayment, false claim or any other manner of inappropriate billing.

_____ I understand services cannot be provided until the Caregiver Coordinator has approved this agreement and returned a copy to me.

F.

Signature:	Date:	Approved:	Date:

DISTRIBUTION: **Original** - Human Service Center **Copy** - Provider